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STATE OF NORTH CAROLINA

COUNTY OF GUILFORD

IN THE OFFICE OF
ADMINISTRATIVE HEARINGS
16 DHR 03629

Community Helps Network LLC Petitioner, v. NC Department of Health and Human Services Division of Medical Assistance (DMA) and Eastpointe Human Services (Eastpointe) Respondent.	**FINAL DECISION**

THIS MATTER came to be heard before Administrative Law Judge J. Randall May presiding, on February 11, 2020, in High Point, North Carolina for a Contested Case Hearing. The Decision will be bifurcated. The first part will deal with Respondent, Eastpointe Human Services; and the second part with Respondent, North Carolina Department of Health and Human Services, Division of Medical Assistance (DMA), with the same Petitioner in both.

PROCEDURAL HISTORY

On April 11, 2016, Petitioner Community Helps Network, LLC ("Petitioner"), represented by Attorney W. Eric Medlin, filed a Petition for a Contested Case against the North Carolina Department of Health and Human Services, Division of Medical Assistance, now known as DHB Regional Health Benefits ("DHHS"), represented by Special Deputy Attorney General Brenda Eaddy and Eastpointe Human Services ("Eastpointe"), represented by Attorney Jose A. Coker. There were many delays beginning on April 18, 2016, when Petitioner filed a Motion for Preliminary Injunction, which was denied on May 23, 2016. On June 20, 2016, Eastpointe filed a Motion to Dismiss and Stay Proceedings. During a telephonic hearing on July 21, 2016, Petitioner's counsel orally moved this Tribunal to stay this matter until Petitioner's related Medicaid Investigations Division ("MID") investigation was complete. On July 21, 2016, the Undersigned granted Petitioner's Motion to Stay requiring regular status reports and denied Eastpointe's Motion to Dismiss.

Attorney Quinton D. Byrd gave notice of appearance for Eastpointe; however, he withdrew his appearance on September 18, 2017. Notice of substitution of counsel was filed by Attorney John F. Bloss for Attorney Eric Medlin on July 19, 2018.

Although Petitioner's MID investigation was not completed, the undersigned lifted the stay of proceedings and entered an Amended Scheduling Order on July 26, 2018. Petitioner and DHHS then filed cross Motions for Summary Judgment, which were denied on November 21, 2018.

Respondent's motion to continue a scheduled hearing was granted on February 8, 2019.

On March 22, 2019, the Undersigned entered a second order staying the case with required status reports until this matter could be heard for the contested case hearing. This stay was subsequently lifted October 3, 2019. This matter came on for a contested case hearing on February 11, 2020. At the close of Petitioner's case-in-chief on February 11th, the courthouse experienced an emergency evacuation by the fire marshal because of a substantial water leak. On May 5, 2020, the balance of the contested case hearing was continued by various Covid-19 orders. In the interim, the Undersigned ordered DHHS and Eastpointe to submit their Motions for Involuntary Dismissal. This Tribunal denied Respondents' Motions for Involuntary Dismissal and took the matter under advisement based upon the evidence presented at the February 11, 2020 hearing.

A global virtual hearing on pending motions was set for July 10, 2020; however, during the week of July 20–24, 2020, the High Point courthouse had no internet access, which required the motion hearing to be postponed. On September 15, 2020, the parties' joint motion was granted to file proposed final decisions. On November 3, 2020 Eastpointe's objections to Petitioner's clarification was filed.

The parties were instructed to file their admitted exhibits with the Office of Administrative Hearings. This was followed-up with a conference call on January 8, 2021.

Again, prior to issuing a final decision, the courthouse sprinkler system ruptured causing the fourth floor of the courthouse to be closed from January 11, 2021 to February 1, 2021.

APPEARANCES

Petitioner was represented by John F. Bloss of Higgins Benjamin, PLLC. DHHS was represented by Brenda Eaddy of the North Carolina Department of Justice. Eastpointe was represented by Jose A. Coker of The Charleston Group.

APPLICABLE LAW

The laws and regulations applicable to this contested case are Chapter 108C and Chapter 150B, Article 3 of the North Carolina General Statutes.

BURDEN OF PROOF

Under N.C.G.S. § 108C-12(d), Petitioner has the burden of proof as to any "adverse determination." The definition of "adverse determination" includes a final decision by the department to deny, terminate, suspend, reduce, or recoup a Medicaid payment or to deny, terminate, or suspend a provider's or applicant's participation in the Medical Assistance Program. *See* N.C.G.S. § 108C-2(1).

ADMITTED EXHIBITS

Petitioner admitted the following exhibits:

1. Petitioner's Exhibit No. 1: Community Helps Network, LLC Suspension Letter dated March 21, 2016.
2. Petitioner's Exhibit No. 2: Respondent DHHS' Answers to Petitioner's First Set of Interrogatories and Response to Request for Production of Documents.
3. Petitioner's Exhibit No. 3: Respondent DHHS' Amended Response to Petitioner's First Set of Interrogatories and First Request for Production of Documents.
4. Petitioner's Exhibit No. 4: Email communication between James Springer and Susan Bryan dated August 11, 2015.
5. Petitioner's Exhibit No. 5: Email communication between James Springer and Susan Bryan dated September 2, 2015.
6. Petitioner's Exhibit No. 6: Community Helps Network, LLC, PI-MID Referral Acknowledgment – Decision Form.
7. Petitioner's Exhibit No. 7: Email communication between James Springer and Susan Bryan dated September 8, 2015.

WITNESSES

Petitioner presented the testimony of:

1. Richard Lide, Co-Owner, Community Helps Network, LLC; and
2. James Springer, Mental Health Program Coordinator, DHB Regional Health Benefits.

CLARIFICATION OF FINAL DECISION

Because of the different parties and issues to be addressed and the actions or inactions involved in the case, this decision will be divided into two parts although the same transcript is referred to in both parts.

PART I

ISSUES

Petitioner contends that Eastpointe substantially prejudiced Petitioner's rights as follows: (i) exceeded its authority or jurisdiction; (ii) acted erroneously; (iii) failed to use proper procedure; (iv) acted arbitrarily or capriciously; and (v) failed to act as required by rule or law, when Eastpointe issued a letter dated March 22, 2016, to Petitioner advising Petitioner of Eastpointe's findings from a Quality of Care Concern lodged against Petitioner. Eastpointe referred its findings to DHHS. DHHS later determined that there were credible allegations of fraud. DHHS then referred Petitioner's case to the MID and issued a suspension of Medicaid payments to Petitioner on March 21, 2016. The issue before this Tribunal as to Eastpointe is whether Eastpointe's action is deemed an adverse determination within the meaning of N.C.G.S. § 108C-2(1); and whether said referral substantially prejudiced Petitioner's rights; exceeded its authority or jurisdiction; acted erroneously; failed to use proper procedure; acted arbitrarily or capriciously; and failed to act as required by rule or law.

BASED UPON careful consideration of the sworn testimony of Richard Lide and James Springer presented at the hearing; the exhibits received and admitted into evidence; and the arguments of counsel, the undersigned makes the following Findings of Fact and Conclusions of Law.

FINDINGS OF FACT

1. Petitioner is a provider of mental health and behavioral health services with its principal place of business in Greensboro, North Carolina. Petitioner provided Intensive In-Home services, Outpatient Therapy, and Psychosocial Rehabilitation services.

2. Eastpointe, a Local Management Entity/Managed Care Organization ("LME/MCO") and Prepaid Inpatient Health Plan ("PHIP"), is a multi-county area mental health, developmental disabilities, and substance abuse authority established pursuant to N.C.G.S. § 122C-115(c).

3. Pursuant to Sections 1915(b) and 1915(c) of the Social Security Act, the United States Department of Health and Human Services has waived portions of North Carolina's traditional "fee-for-service" Medicaid programs and allowed them to be replaced with a managed care program, also known as a 1915(b)/(c) Medicaid Waiver, with closed networks of providers managed by an LME/MCO/PIHP.

4. Eastpointe contracted with DHHS to operate the 1915(b)/(c) Medicaid Program as a managed care program for its ten (10) county catchment area.

5. Petitioner provided services to constituents within certain LME/MCO's catchment areas until DHHS' action suspending Petitioner's Medicaid payments.

6. Eastpointe's Program Integrity Office conducted an initial investigation as a result of a Quality of Care Concern lodged against Petitioner on October 12, 2015, and discovered concerns regarding possible fraud, waste, or abuse after meeting with Petitioner to verify the allegations.

7. Eastpointe forwarded the results of its investigation of Petitioner directly to James Springer ("Springer") in his capacity as DHB Regional Health Benefits, Mental Health Program Coordinator.

8. DHB Regional Health Benefits provides, *inter alia,* oversight to LME/MCOs by reviewing MID referrals from the LME/MCOs such as Eastpointe. As part of its oversight, DHB refers matters to MID if appropriate. (Transcript, p. 47)

9. Springer reviewed the investigation audit completed by Eastpointe on February 11, 2016, and submitted the matter to Patrick Piggott, Associate Director of the North Carolina Medicaid Office of Compliance and Program Integrity ("OCPI") for determination as to referral to MID for further investigation. (Transcript, p. 48).

10. DHHS determined, based on its review of the information received from Eastpointe, that it was appropriate to submit the referral to MID because there was at least an indicium of credible allegations of fraud. (Transcript, p. 79).

11. DHHS made the determination that a credible allegation of fraud existed and to refer the matter to MID based on referrals sent to DHHS regarding Petitioner from multiple sources, including Eastpointe. *See* Petitioner's Exh. 6.

12. On March 21, 2016, Petitioner received its first notice from DHHS that DHHS was suspending Petitioner's Medicaid payments pursuant to 42 C.F.R. § 455.23(a) after a determination by DHHS that there was a credible allegation of fraud for which an MID investigation is pending. (Transcript, pp. 32; 16-24). *See* Petitioner's Exh. 1.

13. On September 8, 2015, DHHS issued PI-MID Referral Acknowledgement – Decision Form noting that DMA Program Integrity's Disposition was to refer Petitioner's fraud referral to MID for investigation. *See* Petitioner's Exhibit 6.

14. DHHS's referral to MID based on Eastpointe's Program Integrity investigation was a supplemental referral, meaning that there was already an existing case with MID involving Petitioner at the time Eastpointe submitted its referral to DHHS. (Transcript, p. 71).

CONCLUSIONS OF LAW

1. OAH has jurisdiction over the parties and the subject matter of this action. Petitioner timely filed the petition for contested case hearing and the parties received proper notice of the hearing in the matter.

2. To the extent that certain portions of the foregoing Findings of Fact constitute mixed issues of law and fact, such Findings of Fact shall be deemed incorporated herein as Conclusions of Law.

3. An Administrative Law Judge need not make findings as to every fact which arises from the evidence and need only find those facts which are material to the settlement of the dispute. *Flanders v. Gabriel,* 110 N.C. App. 438, 440, 429 S.E.2d 611, 612 (1993).

4. N.C.G.S. § 108C-2(3) defines "Department" as the North Carolina Department of Health and Human Services, its legally authorized agents, contractors, or vendors who acting within the scope of their authorized activities, assess, authorize, manage, review, audit, monitor, or provide services pursuant to Title XIX or XXI of the Social Security Act, the North Carolina State Plan of Medical Assistance, the North Carolina State Plan of the Health Insurance Program for Children, or any waivers of the federal Medicaid Act granted by the United States Department of Health and Human Services.

5. N.C.G.S. § 108C-2(1) defines "adverse determination" as "[a] final decision by the Department to deny, terminate, suspend, reduce, or recoup a Medicaid payment . . . ."

6. DHHS suspended Medicaid payments to Petitioner in a letter dated March 21, 2016. *See* Petitioner's Exh. 1.

7. DHHS's decision to suspend Petitioner's Medicaid payments is an adverse determination within the meaning of N.C.G.S. § 108C-2(1) and is subject to the contested case provisions of N.C.G.S. § 150B-23.

8. Eastpointe is an LME/MCO established pursuant to N.C.G.S. § 122C-115(c) and operates a 1915(b)/(c) Medicaid Waiver pursuant to its contract with DHHS.

9. Section 14.3.4 of Eastpointe's Contract with DHHS, DMA-MCO-2018-3 and its amendments, prohibits Eastpointe from suspending a network provider's Medicaid payments, including Petitioner, without prior written approval from DHHS.

10. Petitioner has not proven by a preponderance of the evidence that Eastpointe made a final decision to deny, terminate, suspend, reduce, or recoup Petitioner's Medicaid payments. Therefore, Eastpointe has not made an adverse determination within the meaning of N.C.G.S. § 108C-2(1) and is not subject to the contested case provisions of N.C.G.S. § 150B-23.

11. Eastpointe is required by N.C.G.S. § 122C-111 to monitor its network providers' compliance with all applicable laws.

12. Eastpointe is required by 10A NCAC 27G .0606(a) to investigate Quality of Care Concerns lodged against providers within its catchment area, which included Petitioner.

13. Section 14.2.8 of Eastpointe's Contract with DHHS, DMA-MCO-2018-3 and its amendments, requires Eastpointe to investigate all potential allegations of fraud and forward the results of the investigation to DHHS.

14. Section 9.8 of Eastpointe's Contract with DHHS, DMA-MCO-2018-3 and its amendments, requires Eastpointe to report to DHHS all suspected and confirmed cases of provider fraud and abuse.

15. Petitioner has not proven by a preponderance of the evidence that Eastpointe did not comply with applicable law by investigating the Quality of Care Concern lodged against Petitioner and referring to DHHS the results of its investigation. As the content of the alleged credible allegation of fraud is protected by the shield of federal law, it is impossible to determine any deficient behavior attributable to Eastpointe.

16. Petitioner has not proven by a preponderance of the evidence that Eastpointe has (i) exceeded its authority or jurisdiction, (ii) acted erroneously (iii) failed to use proper procedure, (iv) acted arbitrarily or capriciously, or (v) failed to act as required by law or rule by referring to DHHS the results of its investigation of a Quality of Care Concern lodged against Petitioner.

17. Petitioner has not proven by a preponderance of the evidence that Petitioner was substantially prejudiced by Eastpointe in Eastpointe's referral to DHHS of the results of its investigation of a Quality of Care Concern lodged against Petitioner.

FINAL DECISION OF PART I

NOW, THEREFORE, based on the foregoing Findings of Fact and Conclusions of Law of Part I of this Decision, this Tribunal determines that Eastpointe has not made an adverse decision as to Petitioner within the meaning of N.C.G.S. § 108C-2(1). The Undersigned further finds that Eastpointe was required by law to investigate the Quality of Care Concern lodged against Petitioner and to forward the results of said investigation to DHHS as it did in this case. By referring the results of its investigation as to allegations of fraud on the part of Petitioner, Eastpointe has not (i) exceeded its authority or jurisdiction; (ii) acted erroneously; (iii) failed to use proper procedure; (iv) acted arbitrarily or capriciously; or (v) failed to act as required by law or rule. Eastpointe has not substantially prejudiced Petitioner's rights. Therefore, this Tribunal dismisses the Petition for Contested Case as to Eastpointe with prejudice.

The appellate rights of Part I will be included and recited for the parties in the NOTICE OF APPEAL OF PART I AND PART II.

PART II

In this part the same facts, exhibits, transcript, and counsel apply, which were recited in the Preamble and Procedural History of Part I.

ISSUES

1. Whether the suspension of Petitioner's Medicaid payments has continued for such a duration as to no longer be temporary.

2. Whether the continued suspension of Medicaid payments to Petitioner without meaningful disclosure by Respondent of evidence justifying the suspension or an opportunity to confront and cross-examine adverse witnesses would amount to a violation of Petitioner's due process rights under federal and state law.

3. Whether Respondent, NC Department of Health and Human Services Division of Medical Assistance (DMA), substantially prejudiced Petitioner's rights; exceeded their authority and jurisdiction; acted erroneously; failed to use proper procedure; acted arbitrarily or capriciously; or failed to act as required by law or rule when they suspended Medicaid payments to Petitioner.

FINDINGS OF FACT

BASED UPON further careful consideration of the sworn testimony of the witnesses presented at the hearing; the documents, exhibits received and admitted into evidence; and the

entire record in this proceeding including evidence and various motions, exhibits, arguments, and briefs of the parties submitted and accepted throughout the pendency of this matter; the undersigned Administrative Law Judge ("ALJ") makes the following Findings of Fact. In making these Findings of Fact, the ALJ has weighed all the evidence and including all of Part I of this Decision; and has assessed the credibility of the witnesses by taking into account the appropriate factors for judging credibility, including, but not limited to the demeanor of the witnesses; any interests, bias, or prejudice the witness may have; the opportunity of the witness to see, hear, know or remember the facts or occurrences about which the witness testified; whether the testimony of the witness is reasonable; and whether the testimony is consistent with all other believable evidence in the case.

1. Medicaid is a cooperative federal-state program that provides medical assistance to eligible categorically needy individuals. Respondent DMA is responsible for administering the North Carolina Medicaid program in accordance with the Social Security Act and its implementing regulations, including but not limited to investigating allegations of fraud and abuse against providers enrolled in the N.C. Medicaid program.

2. Petitioner, Community Helps Network, LLC, was at the time it filed this Petition for a Contested Case Hearing, a behavioral/mental health provider. According to the testimony of Richard Lide, one of Petitioner's principals, Petitioner began business in 2007 and, before it closed its doors in 2016 as a result of the suspension orders at issue, operated seven locations in North Carolina. Medicaid billings represented approximately 90% of its revenues.

3. Respondent Eastpointe is a Local Management Entity/Managed Care Organization ("LME/MCO"), responsible for governance and administration of public mental health, developmental disabilities, and substance abuse services in several North Carolina counties. As an LME/MCO, Eastpointe is responsible for the management of Medicaid and state funding for mental and behavioral health services within its territory, as well as oversight.

4. DMA is responsible, *inter alia*, for providing oversight to LME/MCOs.

5. Susan Bryan, a former employee of Eastpointe, referred an undisclosed allegation of fraud relating to Petitioner in/about August 2015. NCDHHS's employee, James Springer, in turn, referred the matter to the N.C. Medicaid Investigations Division ("MID") on the basis that Eastpointe had referred a credible allegation of fraud against Petitioner.

6. In a letter to Petitioner from Eastpointe dated March 22, 2016 (the "Eastpointe Letter"), Eastpointe stated that it had reviewed selected records of Petitioner and determined that "[t]he review indicates services were provided outside of the requirement of current local state, and federal policies and trends are present that support the allegations of possible fraud, waste or abuse activities."

7. In a letter to Petitioner from DMA dated March 21, 2016 (the "DMA Letter"), Respondent DMA informed Petitioner that DMA had received a credible allegation of fraud against Petitioner from Eastpointe; that DMA reviewed Eastpointe's allegations and determined the allegations had an indicium of reliability; and that DMA was not required to disclose any

specific information concerning the investigation. Based on the foregoing, the DMA Letter advised Petitioner that payments to Petitioner were suspended as of March 22, 2016, and that the suspension was **temporary** (emphasis added) and would exist until either (i) the prosecuting agency determined there was insufficient evidence of fraud; or (ii) legal proceedings related to the fraud were completed.

8. As a result of the payment suspension, Petitioner was unable to collect outstanding invoices due and owing from NCDHHS, Eastpointe, and other LME/CMOs; could not pay its employees and creditors; and was unable to continue its business.

9. Both Respondents have refused to provide in discovery any documents or information relating to the ground(s) for their determination that a credible allegation of fraud had been made against Petitioner that justified DMA's suspension of payments earned by Petitioner. Respondents contend that the documents and information requested are confidential pursuant to 10A NCAC 22F .0106, which provides as follows:

> All investigations by the Division concerning allegations of provider fraud, abuse, over-utilization, or inadequate quality of care shall be confidential, and the information contained in the files of such investigations shall be confidential, *except as permitted by State or Federal law or regulation.*

(Emphasis added).

10. On or about June 13, 2017, NCDOJ returned to Petitioner's custody the Petitioner's computers that the State seized from Petitioner in early 2016. Mr. Lide testified that he was aware of no indication of any investigative activity by MID since the payment suspension. And, DMA's witness, James Springer, testified that the only indication that DMA has of an investigation by MID are the quarterly reports from MID stating that an investigation of Petitioner is still pending (for over four years at this time).

11. In this proceeding Respondent has rebuffed the efforts by Petitioner to allow them to identify the purported allegation of fraud that Respondents supposedly found credible. Documents received by Community Helps Network LLC's ("CHN") counsel which were received from Eastpointe (in March 2016 in response to CHN's public records request collectively, the "PRR Documents") provide support for Petitioner's position that Respondents lacked legitimate justification for their actions.

12. An August 11, 2015 email from Springer to Bryan provided in the PRR Documents makes the following request: "Can you please send me a copy of the Investigative Report of Community Helps Ne4twork [sic], LLC/Valerie Murray in a Word document format." (Petitioner's Exh. 4).

13. A September 2, 2015 email from Springer to Defendant Bryan (Petitioner's Exh. 5), states as follows:

> We may be able to send this to MID. I need some additional information.

1. From your referral:

> "A review of billing from 5/1/14 to 3/2/15 identified only 39 E/M[1] codes. This is less than 1% of all outpatient billing submitted by provider during this timeframe 39/5088=.008). (Valerie Murray's LIP[2] application with Eastpointe identified her hours at Community Helps Network as 8 a.m. to 7 p.m. on Tuesdays. Community helps Network is a CABHA[3] and Dr. Murray is identified as the Medical Director on Community Helps Network's Eastpointe application. Dr. Murray has a private practice in Fayetteville, NC. Dr. Murray has submitted NO billing to Eastpointe as an LIP.) Based on Dr. Murray's hours at Community Helps and the review of documentation in the 6/1/14 to 8/30/14 timeframe, it is unlikely that Dr. Murray is the attending provider for basic outpatient therapy services as the billing reflects."

Did you get a copy of Dr Murray's work schedule? Was Dr Murray interviewed and asked if she actually saw the recipients? Is there any documentation of services provided by Dr Murray? Did the provider bill for services not rendered by Dr Murray?

2. From your referral:

> "Provider billed family therapy codes (90846 W/O patient or 90847 W/ patient) for more than one (1) family member on the same Date of Service in three (3) out of four (4) family sets. Per Clinical Coverage Policy 8C Section 5.3, no separate billing for participating member(s) of the therapy session, other than the identified family member, is permissible."

You did not send the service notes for the family therapy dates of service billed.

(*Id.* p. 2; emphasis added).

14. Ms. Bryan's emailed response on the same date (*see* Petitioner's Exh. 5), stated:

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[1] E/M is an abbreviation for Evaluation and Management. Providers must use E/M coding to be reimbursed by Medicaid programs.

[2] Presumably, Dr. Murray's Licensed Independent Practitioner application with Eastpointe. A licensed independent practitioner is a practitioner permitted by law and by the organization to provide care and services, without direction or supervision, within the scope of the practitioner license and consistent with individually assigned clinical responsibilities.

[3] Critical Access Behavioral Health Agency, a type of provider that offers a broad range of mental health and substance abuse services.

> Thank you James. I am following up on your request for additional information. I also received a call today from Sandhills stating concerns with this provider; however, I can't tell you if they are sending a referral to DMA. Sandhills maybe [sic] able to provide you with additional information.

15. From this document it is apparent that, as of September 2, 2015, Eastpointe's Bryan (a) had not obtained a copy of Dr. Murray's work schedule; (b) interviewed Dr. Murray; or (c) obtained documentation of services provided by Dr. Murray. In other words, as of September 2, 2015, Bryan had not forwarded the requested information to Springer showing credible evidence that Petitioner had billed for services not rendered by Dr. Murray.[4] Likewise, Petitioner presented uncontradicted evidence that it did not knowingly bill separately for individual family members in providing family services in violation of NCDHHS policy.[5] (Tr. 33, 36).

16. Despite Mr. Springer's acknowledgement to Ms. Bryan in his September 2, 2015 email that he required significantly more information to substantiate her referral, Springer nevertheless referred Petitioner to MID on or about September 8, 2015. In doing so, Springer relied solely on Bryan's allegations quoted in Bryan's September 2, 2015 email to Springer and did no independent investigation. (Tr. 72). Ms. Bryan's acknowledgement that his task was to determine for NCDHHS whether a credible allegation of fraud had been made against Petitioner. (Id.).

17. A "PI-MID referral Acknowledgement-Decision Form" (Petitioner's Exh. 6) provided in the PRR Documents, issued by DMA on September 8, 2015, the date of Mr. Springer's referral of CHN to MID, shows that Bryan and Springer, as "Integrity Liaisons," not the Medicaid agency, had caused the referral to be issued due to alleged "Fraud" by CHN; however, the final decision was MID'S. The form describes the "Nature of Allegation" as "Billing for Services not

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[4] Indeed, the relevant provisions of DMA's rules in effect at that time expressly set forth that the provider's physician responsible for outpatient therapy services (here, Dr. Murray) *was not required to be on the provider's premises when the services were provided*. Rather, DMA's rules, provided, a "provisionally licensed therapist" could provide "reimbursable services that can be billed 'incident to' the services of a physician under the physician provider number" as long as, *inter alia*, the physician was

> readily available to the provisionally licensed professional at all times. (This means readily available by phone and able to return to the office if the patient's condition requires it. The physician does not have to be on the same premises; however, the premises must be the location where the physician practices . . .)

Clinical Coverage Policy No. 8C, §§ 6.21, 6.23(b) (rev. 1/1/2012) (Exhibit A, not included).

[5] To the best Petitioner can determine given Respondents' refusal to provide information on this issue, some members of the families that were the subject of Ms. Bryan's allegations were obtaining services from a different provider in Eastpointe's catchment area, and to the extent that Petitioner and another provider separately billed family members who were receiving family therapy, the error was Eastpointe's, not Petitioner's.

rendered," "'Upcoding' or inappropriate/inflated billing," and "Other: Billing 'incident to' without SC modifier and without documented physician oversight of cases."

18. In a September 8, 2015 email to Ms. Bryan (Petitioner's Exh. 7), Mr. Springer, on the same date he had referred CHN to MID, in his words, "provided feedback to" (Tr. 66-67) Ms. Bryan for the apparent lack of evidentiary support for her allegations, as follows:

> The case was referred to MID as a supplemental referral. For future MID referrals, include the family service notes in the referral. Service notes are the only way to know what the provider actually did. I (and MID) need the service notices to compare to the policy and procedure code billed. If there is a suspicion of a provider billing for services not rendered it is good to interview the provider and ask if they saw the recipients. You can also ask for the provider's work schedule, calendar and compare them with the billing for that provider. According to 108C, a provider can be terminated for refusing to cooperate with investigations and audits.

19. The payment suspension has continued for more than five years after DMA's referral of Petitioner to MID, and four-and-a-half years after the suspension of Medicaid payments earned by Petitioner. Therefore, I find that under these circumstances the payment suspension is no longer "temporary."

BASED ON the foregoing Findings of Fact, the Court makes the following:

CONCLUSIONS OF LAW

1. The Office of Administrative Hearings has both subject matter and personal jurisdiction of this contested case hearing pursuant to N. C. Gen. Stat.§ 150B-23 *et. seq.* All necessary and proper parties have been joined. Parties received timely and appropriate notice of the hearing.

2. To the extent that findings of fact contain conclusions of law or that conclusions of law are findings of fact, they should be so considered without regard to given labels.

A. THE PAYMENT SUSPENSION IS NO LONGER TEMPORARY.

3. Pursuant to federal regulation, any suspension of Medicaid payments by a State Medicaid agency must be temporary:

> Duration of suspension.
>
> (1) All suspension of payment actions under this section *will be temporary* and will not continue after either of the following:

(i) The agency or the prosecuting authorities determine that there is insufficient evidence of fraud by the provider.

(ii) Legal proceedings related to the provider's alleged fraud are completed.

42 FR 455.23(c).

4. DMA presented evidence that MID continues to represent in quarterly reports that a criminal investigation of CHN is ongoing.

5. Nevertheless, "federal courts have stated that the government may not deprive a provider of such funds indefinitely without a hearing." *Maynard v Bonta,* 2003 U.S. Dist. LEXIS 16201, *57 Cal. Aug. 29, 2003) (citations omitted). As a result, "where the governing statutes and regulations provide that withholding may be 'temporary' only, a provider can 'regain' his property interest in the withheld funds if the investigation continues indefinitely. *Id.,* 2003 U.S. Dist. LEXIS 16201 at *59. *See also* Pressley Ridge Sch. V. Stottlemyer, *947 F. Supp. 929, 940* (D. W. Va. 1996) ("Defendants violated [42 C.F.R. § 455.23] when they suspended payments to Pressley Ridge indefinitely for Behavioral Management Services. . . . Suspension of payments is authorized only by 42 C.F.R. § 455.23 and can be instituted only in accordance with its provisions").

6. After four years the payment suspension applicable to Petitioner is no longer temporary.

B. ALLOWING THE PAYMENT SUSPENSION TO CONTINUE WOULD VIOLATE PETITIONER'S CONSTITUTIONALLY PROTECTED RIGHTS.

7. Temporary cannot be an ambiguous term. It must have a terminus, or "due process" is meaningless. The interpretation posited by Respondent allows "temporary" to have an infinite meaning. This seems contrary to the meaning forecast in 42 C.F.R. § 455.23.

8. Petitioner has a property interest, giving rise to a constitutional right of due process, in the payments earned but withheld due to DMA's suspension order. It is fundamental that due process affords a person whose property rights are imperiled the opportunity to learn the nature of the claims being made against it and to cross-examine the persons responsible for those claims.

9. Article I, Section 1 of the North Carolina Constitution declares that "we hold it to be self-evidence that all persons are created equal; that they are endowed by their Creator with certain inalienable rights; that among these are life, liberty, the enjoyment of the fruits of their own labor, and the pursuit of happiness."

10. Article I, Section 19 of the North Carolina Constitution states that "no person shall be taken, imprisoned, or disseized of his freehold, liberties, or privileges, or outlawed, or exiled, or in any manner deprived of his life, liberty, or property, but by the law of the land."

11. The Due Process Clause of the Fifth Amendment to the United States Constitution guarantees that "no person shall be . . . deprived of life, liberty, or property, without due process of law."

12. The expression "the law of the land" as used in Article I, Section 19 of the North Carolina Constitution is synonymous with the expression "due process of law."

13. A similar protection, that no "State shall deprive any person of life, liberty, or property, without due process of law" is contained in the Fourteenth Amendment to the United States Constitution.

14. 42 C.F.R. 455.13, applicable to investigations of alleged Medicaid fraud, provides as follows:

> The Medicaid agency must have—
> (a) Methods and criteria for identifying suspected fraud cases;
> (b) Methods for investigating these cases that—
> (1) *Do not infringe on the legal rights of persons involved*; and
> (2) *Afford due process of law*; and
> (c) Procedures, developed in cooperation with State legal authorities, for referring suspected fraud cases to law enforcement officials.

(Emphasis added).

15. It is undeniable that Petitioner has a property interest, giving rise to a constitutional right of due process, in payments earned but withheld due to DMA's suspension order. *Accord Shankar v. Bonta*, 8402002 WL 31296204 at *840 (9th Cir. Oct. 11, 2002) (Medicaid provider "had a property interest in the earned payments that were temporarily withheld" by State). Indeed, the Courts in this jurisdiction have held that a property interest exists with respect to a Medicaid provider's right to continue to participate in the program *in the future*. *Accord Ram v. Heckler*, 792 F.2d 444, 447 (4th Cir. 1986) (physician suspended from participating in Medicare and Medicaid programs had "expectation of continued participation in the medicare program [constituting] a property interest protected by the due process clause of the fifth amendment"); *Bowens v. N.C. Dept. of Human Resources*, 710 F.2d 1015, 1018, 1019 (4th Cir. 1983) (Medicaid service "provider's participation is not terminable at the will of the state. Consequently, we conclude that the regulations create a property interest in continued participation the program unless terminated for cause. . . . *When a property interest has been created, the due process clause, not state regulations, defines what process is constitutionally mandated*" (emphasis added)); Nanny's Korner Care, *supra,* 234 N.C. App. at 64, 758 S.E.2d at 431 ("[G]iven the documented evidence in the record showing the impact of DHHS's administrative action on Petitioner's livelihood, Petitioner has arguably suffered a deprivation of her liberty interests guaranteed by our State's constitution, necessitating a procedural due process analysis"); *Team Daniel, LLC v. N.C.D.H.H.S.,* 12 DHR 02162 ¶¶ 31-40 (OAH Cumberland County Sept. 11, 2012) (Overby, ALJ) (property interest in continued participation existed even after changes in applicable N.C. regulations relating to Medicaid providers).

16. It is fundamental that due process affords a person whose property rights are imperiled the opportunity to learn the nature of the claims being made against it and to cross-examine the persons responsible for those claims. As the Fourth Circuit has instructed

> *In almost every setting where important decisions turn on questions of fact, due process requires an opportunity to confront and cross-examine adverse witnesses….*
>
> Certain principles have remained relatively immutable in our jurisprudence. One of these is that where governmental action seriously injures an individual, and the reasonableness of the action depends on fact findings, *the evidence used to prove the Government's case must be disclosed to the individual so that he has an opportunity to show that it is untrue*. While this is important in the case of documentary evidence, it is even more important where the evidence consists of the testimony of individuals whose memory might be faulty or who, in fact, might be perjurers or persons motivated by malice, vindictiveness, intolerance, prejudice, or jealousy. We have formalized these protections in the requirements of confrontation and cross-examination. *This Court has been zealous to protect these rights from erosion. It has spoken out in all types of cases where administrative actions were under scrutiny.*

McNeill v. Butz, 480 F.2d 314, 321-22 (4th Cir. 1973) (emphasis added; citations, punctuation omitted).

17. Even if it were appropriate for Respondents *temporarily* to withhold the information relating to the supposed reason(s) for DMA's finding that a credible allegation of fraud had been made, the time has long passed to justify the information being withheld. *See*, *e.g.*, *Ram v. Heckler*, *supra*, 792 F.2d at 447 (Medicaid provider's property interest in continued participation "does not merit the protection of a pre suspension hearing. . . . Ram is entitled, however, to a prompt post suspension hearing that should proceed and be concluded without unreasonable delay to determine whether his fault warrants a one-year suspension"). *See also Mednik v. State Dept. of Health Care Svcs.*, 96 Cal. Rptr.3d 112, 126, 175 Cal. App.4th 631, 647 (2009) ("[T]he purpose of the temporary suspension [of a Medi-Cal provider during a fraud investigation] is to maintain the integrity of the Medi-Cal system while the Department or another enforcement agency determines whether the evidence will support a criminal or civil case against the provider. There must come a point at which the Department determines that such a case is either supported by the evidence or not"). *See generally Barry v. Barchi*, 443 U.S. 55, 66 (1979) ("Once suspension has been imposed, the [petitioner's] interest in a speedy resolution of the controversy becomes paramount, it seems to us. We also discern little or no state interest, and the State has suggested none, in an appreciable delay in going forward with a full hearing. . . . In these circumstances, it was necessary that Barchi be assured a prompt post suspension hearing, one that would proceed and be concluded without appreciable delay. *Because the statute as applied in this case was deficient in this respect, Barchi's suspension was constitutionally infirm under the Due Process Clause of the Fourteenth Amendment*" (emphasis added)).

18. At a minimum, due process requires adequate notice of the charges and a fair opportunity to meet them within a reasonable period of time. Otherwise, the word "temporary" has no meaning.

19. Respondent NCDHHS takes the position that it is entitled to a decision in its favor in this contested case merely because its witness, James Springer, testified that he reviewed certain unidentified evidence he received from Eastpointe and concluded that a credible allegation of fraud against Petitioner had been made. Other courts have rejected similar arguments. In *Matter of Able Health Servs. Inc. v New York State Off. of the Medicaid Inspector Gen.,* 59 Misc. 3d 171, 192-194, 67 N.Y.S.3d 755, 771-772 (2017), for example, 3½ years after New York's Office of the Medicaid Inspector General ("OMIG") suspended a Medicaid provider's ("Able") payments on the ground that some credible allegation of fraud had been made against Able, the court ordered the suspension order lifted, as follows:

> In the end, respondent's argument distills to this: MFCU [New York's Medicaid Fraud Control Unit] has said certain practices are fraudulent, and has cited a myriad of statutes that it claims may have been violated, and OMIG [Office of the Medicaid Inspector General] need not look behind these claims. *But if "independent review" has any meaning, it must consist of more than the investigating body reciting the incantation of "fraud," and OMIG relying thereon. There must instead be some hint of an explanation as to who might have been defrauded, to what end, and how that might have deprived the State of funds which it must protect via its withholding power.* I cannot see how this could be the case here if the alleged fraud concerns documentation of an evaluation that Able was never required to perform. Yet search as I might through respondent's submissions, I see no argument that contests this assertion.
>
> In light of the foregoing, the petition is granted. *Respondent is hereby directed to nullify its February 6, 2017 notice and imposition of a 10% withholding, and to refund all Medicaid payments that have been withheld from Able* since February 6, 2017, within 20 days of service upon it of this decision and order (emphasis added).

59 Misc. 3d at 192-194, 67 N.Y.S.3d at 771-772.

20. Allowing the payment suspension applicable to Petitioner to continue would violate rights guaranteed to Petitioner under the federal and state constitutions and, accordingly, must be lifted.

C. RESPONDENT HAS MADE NO TIMELY SHOWING OF SUBSTANTIVE EVIDENCE OF PETITIONER'S FRAUD, AS DEFINED IN 42 C.F.R. 455.2, AT THE TIME THE REFERRAL TO MID WAS MADE.

21. Throughout this proceeding Respondent has refused to provide details about the allegation of fraud made against Petitioner and/or how they purportedly concluded that the allegation was credible at the time the referral to MID was made.

22. Pursuant to 42 C.F.R. 455.2, a federal regulation which governs NCDHHS's actions for purposes relevant here, "fraud" is defined as "an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or State law.

23. An online reference manual entitled, "Health Care Fraud and Program Integrity: An Overview for Providers" (the "CMS Manual"), published in about September by the Centers for Medicare & Medicaid Services ("CMS")[6], states as follows:

> For purposes of enforcement, there is a difference between unintentional mistakes and fraudulent or abusive behavior. For example, submitting an erroneous claim for payment is different from submitting the same claim with actual knowledge, reckless disregard, or deliberate ignorance of its falsity. An honest mistake should lead to the return of funds to Medicaid. Providers who improperly bill for services and beneficiaries who cause unnecessary costs risk losing continued eligibility to participate in the Medicaid program and may face criminal and civil monetary penalties.

CMS's distinction between "unintentional mistakes" and "fraudulent or abusive behavior" as quoted in the previous Paragraph is an accurate description of the distinction for purposes relevant here to providers such as Petitioner during the time frames at issue here.

24. A "credible allegation of fraud," pursuant to 42 C.F.R. 455.2:

> may be an allegation, *which has been verified by the State*, from any source, including but not limited to the following:
>
> (1) Fraud hotline complaints.
> (2) Claims data mining.
> (3) Patterns identified through provider audits, civil false claims cases, and law enforcement investigations. *Allegations are considered to be credible when they have indicia of reliability and the State Medicaid agency has reviewed all allegations, facts, and evidence carefully and acts judiciously on a case-by-case basis*.

(Emphasis added).

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[6] https://dbhids.org/wp-content/uploads/2015/10/Health-Care-Fraud-and-Integrity-An-Overview-for-Providers.pdf.

25. From the evidence presented, no "credible allegation of fraud," as defined in 42 C.F.R. 455.2, was made against Petitioner in connection with the referral to MID. Despite the mandate in 42 C.F.R. 455.2 that an allegation of fraud is considered credible only when "verified by the State," NCDHHS, by Springer's admission, undertook no independent investigation or otherwise verified the supposed allegation of fraud before referring the matter to MID. And there is no evidence that Respondents reviewed allegations, facts, and evidence and "acted judiciously" in connection with the referral to MID.

26. The CMS Manual states, "As a practical matter, a State Medicaid agency's referral of the allegation to the State Medicaid Fraud Control Unit (MFCU*) after such verification and review amounts to a determination* that a credible allegation of fraud exists."

27. In *Nanny's Korner Care Ctr. v. N.C. HHS - Div. of Child Dev.,* 234 N.C. App. 51, 63-64, 758 S.E.2d. 423, 430-431 (2014), a local Department of Social Services concluded, after an investigation at a child-care facility, that sexual abuse had occurred, and issued a "protection plan" preventing the employee who allegedly committed the abuse from being on the premises while children were present. 234 N.C. App. at 53, 758 S.E.2d at 424. Relying solely on DSS's investigatory findings, NCDHHS issued a written warning to the child-care center and prohibited the employee from being on the child-care center's premises while children were on site. 235 N.C. App. 51, 759 S.E.2d at 424. The Court of Appeals vacated and remanded, holding that "a plain reading of the pertinent statutes and administrative rules places an affirmative duty on DHHS to independently substantiate abuse before it can issue a warning to a facility and mandate corrective action." 234 N.C. App. at 59, 758 S.E.2d at 428.

28. Decisions from other jurisdictions interpreting 42 CFR 455.23 are in accord. *See, e.g., Matter of Consumer Directed Choices, Inc. v. New York State Off. of The Medicaid Inspector Gen.,* 90 A.D.3d 1271, 1273 n.2, 935 N.Y.S.2d 352, 354 n. 2 (N.Y. App. 2011) (the current version of [42 CFR 455.23], which became effective in March 2011, requires the withholding agency to "*determine*[ ] there is a credible allegation of fraud for which an investigation is pending" . . . The comments published in the Federal Register indicate that *this requires some independent review of the evidence of fraud* (emphasis in original; citing 76 Fed Reg 5862, 5936 [2011], codified at 42 CFR part 1007))).

29. Here, as in *Nanny's Korner*, the statutes and administrative rules placed an affirmative duty on NCDHHS to independently substantiate whether an allegation of fraud was credible. From the evidence presented, that did not happen here. *See also Matter of Able, supra*; *Janek v. Harlingen Family Dentistry, P.C.,* 451 S.W.3d 97, 103 (Tex. App 2014) ("[U]nder both the Texas statute and the applicable federal regulation, any payment hold was temporary and had to end if credible evidence of fraud was found to be lacking. *Here, the ALJ found that HHSC failed to make prima facie showing of any right to withhold payment based on fraud or willful misrepresentation.* The ALJ concluded that HHSC therefore lacked authority to withhold funds on that basis. . . . The State's right to temporarily possess any of these funds was based solely on the existence of credible evidence of fraud. Thus, *a finding of the absence of such evidence could only mean that the State's right to temporary possession of the funds no longer existed*" (emphasis added).

30. The Undersigned concludes, as have courts addressing similar arguments, that Respondents' failure to come forward with any evidence during this extended period, supporting their assertion of that a credible allegation of fraud was made against Petitioner is insufficient to justifying continued suspension of payments earned by Petitioner. To allow Mr. Springer to make this decision for the length of time the Petitioner has been deprived of due process prohibits this tribunal, or any other court, of interpreting the law.

31. From the evidence presented, Respondent had no disclosed substantive evidence of "fraud" by Petitioner, as defined in 42 C.F.R. 455.2 or otherwise, at the time the referral to MID was made. Accordingly, the payment suspension applicable to Petitioner must be lifted.

FINAL DECISION OF PART II

NOW THEREFORE, based upon the foregoing Findings of Fact and Conclusions of Law in Part II of this Decision, it is ORDERED, ADJUDGED, AND DECREED that the Petitioner's petition is granted, and the DMA's suspension order is hereby lifted and from this point forward is void and of no legal effect.

NOTICE OF APPEAL OF PART I AND PART II

These are the Final Decisions issued under the authority of N.C. Gen. Stat. § 150B-34.

Under the provisions of North Carolina General Statute § 150B-45, any party wishing to appeal the final decision of the Administrative Law Judge must file a Petition for Judicial Review in the Superior Court of the county where the person aggrieved by the administrative decision resides, or in the case of a person residing outside the State, the county where the contested case which resulted in the final decision was filed. **The appealing party must file the petition within 30 days after being served with a written copy of the Administrative Law Judge's Final Decision**. In conformity with the Office of Administrative Hearings' rule, 26 N.C. Admin. Code 03.0102, and the Rules of Civil Procedure, N.C. General Statute 1A-1, Article 2, **this Final Decision was served on the parties as indicated by the Certificate of Service attached to this Final Decision**. N.C. Gen. Stat. § 150B-46 describes the contents of the Petition and requires service of the Petition on all parties. Under N.C. Gen. Stat. § 150B-47, the Office of Administrative Hearings is required to file the official record in the contested case with the Clerk of Superior Court within 30 days of receipt of the Petition for Judicial Review. Consequently, a copy of the Petition for Judicial Review must be sent to the Office of Administrative Hearings at the time the appeal is initiated to ensure the timely filing of the record.

SO ORDERED this the 20th day of January, 2021.

J. Randall May
Administrative Law Judge

CERTIFICATE OF SERVICE

The undersigned certifies that, on the date shown below, the Office of Administrative Hearings sent the foregoing document to the persons named below at the addresses shown below, by electronic service as defined in 26 NCAC 03 .0501(4), or by placing a copy thereof, enclosed in a wrapper addressed to the person to be served, into the custody of the North Carolina Mail Service Center who subsequently will place the foregoing document into an official depository of the United States Postal Service:

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This the 20th day of January, 2021.

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